

AN ISSUE PAPER  
ON  
THE USE OF TITLE XIX (MEDICAID)  
FOR DEVELOPMENTAL ACHIEVEMENT  
CENTER SERVICES AND SEMI-INDEPENDENT  
LIVING SERVICES TO THE  
MENTALLY RETARDED IN MINNESOTA

A REPORT OF THE  
ADVISORY COUNCIL ON MENTAL  
RETARDATION AND PHYSICAL DISABILITIES

OCTOBER 22, 1981

## LEGISLATIVE HISTORY

In 1967, the Congress approved an amendment to Title XIX (General Provisions) of the Social Security Act authorizing Federal matching for a new classification of care, called "intermediate". An intermediate care facility (ICF) was intended to provide less expensive care than a skilled nursing facility for persons professionally determined to need institutional care above the level of room and board, but below that of skilled nursing care.

In an effort to broaden the coverage for intermediate care, an amendment to the Social Security Act was introduced in 1971 to transfer the ICF program to Title XIX (Medicaid). This amendment gave the Secretary of HEW broad authority to define the conditions under which ICF's would be covered.

The proposed amendment also authorized, for the first time, Federal matching under Medicaid "for care of the mentally retarded in public institutions which have a primary purpose of providing health or rehabilitation services and which are classified as intermediate care facilities" (House Report 92-231). Institutions providing primarily residential or custodial services only would be excluded. This was the first evidence that the new ICF/MR program would require what is now called "active treatment".

The proposed amendment also called for the "regular independent professional review of patients...", making it clear that the standards for the various types of intermediate care facilities being created would reflect the differences in the types of persons and their needs in the various settings. It was recognized that the needs of mentally retarded persons differed from those of the sick or elderly and the independent professional review was intended to see that individuals received the level and type of care they needed in the most appropriate setting.

The proposed amendment (as contained in HR 1) passed the House in 1971 without discussion on the floor of the ICF and ICF/MR provisions. In 1972 the proposed amendment passed the Senate.

The law which contained the amendment was passed in December, 1971 and became P.L. 92-223. The original H.R. 1, which contained the ICF provisions became P.L. 92-603 in early 1972.

Various interest groups have attempted to explain what the intention of the Congress was when the ICF/MR provisions were added to the Social Security Law. It appears that the most reasonable statement which can be made is that the program was intended to help publicly operated institutions for the mentally retarded upgrade their facilities and services with Federal financial assistance. It can also be said that it was clear that the expectation was that facilities would have to demonstrate that they were in fact providing health or rehabilitation services to their residents to participate in the program. It is also reasonable to interpret the intent of the Congress that those services would be provided within the institution, especially since models of community-based programs were not widely available at that time, and certainly not for persons residing in public institutions for the mentally retarded. Reference to small facilities was first contained in regulations published in 1974, (Federal Register Vol. 39, No. 12, January 17, 1974). These regulations defined an "institution" to include facilities serving "four or more persons in single or multiple units". That definition

is a generic definition for the ICF program in general and probably was included in recognition that there were small facilities which would be included in the ICF program. While there were a few small residential facilities for mentally retarded persons in 1974, (Minnesota certified the first 24 small ICF's/MR in the country early in 1974.) that model of residential care was by no means widely adopted. Some recognition was given to the possibility of small ICF's/MR being included which resulted in some provisions for facilities serving 15 or fewer persons in the ICF's/MR regulations.

#### Current ICF/MR Regulations

Within the broad authority granted to the Secretary to set standards for ICF's and ICF's/MR, the ICF/MR regulations were first published in 1974. As it happened, there were already voluntary standards for residential facilities for the mentally retarded which had been published by the Accreditation Council for Facilities for the Mentally Retarded (ACFMR), which was then a part of the Joint Commission for Accreditation of Hospitals (JCAH). These standards were heavily oriented toward active treatment services and were therefore considered suitable for the ICF/MR program. Thus, the ICF/MR regulations represented a modified revision of the ACFMR standards.

There were a number of provisions within existing standards which affect the operation of facilities which serve 15 or fewer residential clients. Two of these provisions are of particular interest:

- (1) Professional and Special Programs and Services are those services and procedures necessary for "active treatment" (which will be explained in the next section) to take place. The services to be provided directly or by contract include medical, dental, training and habilitation, nursing, food and nutrition, pharmacy, physical therapy and occupational therapy, psychology, speech pathology and audiology, and recreation services.

These services may be provided by the facility or by contract. However, contracted services must meet the standards for quality of services required in this subpart (442.455) Quality standards for outside resources).

- (2) Staff coverage may be reduced proportionately when the residents are out of the facility during the day. (Interpretative Guideline's for the Application of Standards for Intermediate Care Facilities).

The ICF Guidelines for subsection 442.444 state:

"Facilities sending residents out for a majority of the day for ongoing active treatment, need not provide a full complement of living staff for those residents during that period of their absence. However, adequate coverage is required for those individuals who remain in the facility."

### Active Treatment

An "active treatment" requirement is contained in law (P.L. 92-603) and in regulation (435.1009). The HCFA has actively sought to define "active treatment" as a key service requirement in ICF's/MR. The following is a summary of the expanded definition.

The realization of the active treatment requirement is the result of the convergence of two main elements: a) the characteristics of the individuals certified as in need of ICF/MR placement, and b) the nature of the services which must be provided or contracted for, by the facility to those individuals to meet their developmental needs. Regardless of how these services are gathered together, the provision of active treatment must be met.

In order to understand what active treatment means, it is important to review again the developmental needs of retarded and other developmentally disabled individuals. First of all, the retarded person is typically developmentally delayed across the spectrum of developmental competencies evidenced by non-disabled persons (e.g., social, emotional, cognitive, self-help, daily living, communicative, perceptual-motor, prevocational and vocational skills). Depending upon the extent of the disability, and the extent of prior habilitation, the person may require habilitation services in only a few of the areas, or may require intensive comprehensive services in all areas of development. The ICF/MR must provide or arrange for the services the resident requires. Secondly, it has been well established in research and practice that retarded persons develop best and most rapidly when they participate in a program of treatment which is viewed as a process, in which all individuals who interact with the client participate with consistency, and most importantly, competency. What that means is that not all interventions need to be viewed in terms of what is called "transdisciplinary services", meaning that interventions are provided by many people in various settings under the direction of those professionals who are expert in the particular skills areas being taught. For example, if a person lives in a small residential facility and goes to a DAC during the day and receives assistance from an occupational therapist in self-feeding skills, the transdisciplinary concept means that the DAC staff would provide training to the staff in the small facility so that the self-feeding training techniques would be practiced in the facility at breakfast and dinner, as well as at the center during the "formal" teaching time. HCFA holds that this concept of transdisciplinary intervention is consistent with and accurately defines what is meant by "active treatment", as outlined by the regulations. It is important to note also, that the same requirement for active treatment to be provided in living units of large facilities exists as it does for the small residential alternatives. In other words, if an occupational therapist in a large facility works with a resident on self-feeding skills in a formal setting, the resident living staff should be trained to carry out that same procedure during meal times in the dining areas of the resident living center.

The "active treatment" requirement means that it is not adequate either statutorily, regulatorily, or clinically to provide only supervisory or custodial care in an ICF/MR. Even if the residents may go out of the facility (or away from the living units) for DAC services during the day, active

treatment must be provided in the facility or living unit as well. A corollary is that an ICF/MR need not fulfill the resident's entire need for "active treatment". That requirement can be met jointly by the ICF/MR and the DAC.

Waiver Provisions Under Section 1915(c) of the Omnibus Reconciliation Act of 1981

Federal officials have long discussed the need for reducing service cost for Medicaid eligible persons through provision of non-institutional services. In 1981, as part of the Omnibus Reconciliation Act, Congress provided for three year renewable waivers for states to include home and community-based services to individuals who would otherwise require the level of care provided in an SNF or ICF (Section 1915(c)).

The Act places emphasis on providing services in less costly, noninstitutional service settings. The Act requires that all medical assistance for such services be less, on an average per capita basis, than the total expenditures which would occur if such individuals were institutionalized.

Section 1915(c) of the Act provides the statutory authority for the provision under the Medicaid program of two types of non-institutional service for Medicaid eligible persons:

- (1) DAC services for persons not residing in ICF/MR.
- (2) Semi-independent Living Services (SILS), including apartment-living training, foster care, and case management services.

Medical payments for DAC services for residents of ICF's/MR are authorized under section 249.13(c)(3) "Training and Habilitative Services" of the federal ICF/MR regulations. Such services are defined as "the facilitation of the intellectual, sensorimotor and affective development of the individual". Further, the regulations provide that individual evaluations be performed, an individual program plan be developed, and that services be provided to meet individual training objectives.

Medical payments for SILS, and DAC services for nonresidents of ICF/MRs, are authorized under HCFA regulations published Thursday, October 1, 1981, "Medicaid Program; Home and Community-Based Services". (42 CFR Parts 431, 440 and 441) These new regulations add a section (440.180) defining home and community-based services, 42 CFR Part 440; and a new Subpart G to Part 441 specifying requirements for providing these services. The regulations give states broad latitude in defining these services. However, states must provide assurance that: (1) services will be provided under a written plan of care, (2) the health and safety of clients are protected, and (3) that the services do not cost more, on an average per capita basis, than services provided to an individual in an ICF/MR.

In summary, ICF/MR regulations set the standard for certification and participation in Medicaid and the standard for payment for intermediate care facility services. The services include an "active treatment" requirement which in small facilities can be met through services provided by the ICF/MR and by outside service providers who meet the standards for Professional and Special Programs and Services (442.455). Developmental Achievement Centers clearly meet this standard.

In Minnesota, virtually all ICF/MR residents participate in programs outside of the facility. Two thousand one hundred eighty-seven ICF/MR residents attend a DAC. In other words, DAC's enable ICF's/MR to meet the "active treatment" requirement for 2,187 residents. Furthermore, the ICF/MR residents' participation in DAC programs enable ICF's/MR to reduce the number of staff employed.

In addition, the use of the Title XIX Medicaid program for DAC and SILS services to noninstitutionalized (ICF/MR) persons is clearly appropriate and authorized if the costs of those services are less than those in an ICF/MR.

Therefore, it is concluded that the curtailment of DAC services will very likely place ICF's/MR in non-compliance with the requirement for "active treatment". As a result, continued certification will be threatened, and/or will lead to increased staffing costs within ICF's/MR.

Secondly, DAC services qualify as Professional and Special Services under ICF/MR regulations and are eligible for Medicaid reimbursement for services provided to both residents of ICF's/MR and non-ICF/MR DAC residents.

Finally, under the new HCFA Regulations provisions, the SILS program, as defined in Minnesota, is authorized as home and community-based services.

#### Cost Impacts

The following figures illustrate the impact of "Medicaiding" DAC and SILS services. Several assumptions were used in the computations and appear under each table as they relate to the conversion. These assumptions may need adjustment and would affect the figures if adjustments were made.

TABLE I

#### Cost Implications of Converting DAC Adult Costs to Title XIX FY 82 (6 mo.)(1)

		(In Thousands)		
	<u>Budget</u>	<u>Cty/XX</u>	<u>XIX</u>	<u>State</u>
<u>Current</u> <u>Funding Mode</u>	7618.0	3809.0	-0-	3809.0(2)
<u>Conversion</u>	7618.0	347.4(3)	4143.4(4)	3127.2
<u>Difference</u>	-0-	3461.6	+4143.4	-681.8

	FY 83			
	<u>Budget</u>	<u>Cty/XX</u>	<u>XIX</u>	<u>State</u>
<u>Current</u> <u>Funding Mode</u>	16800.0	8400.	-0-	8400.0
<u>Conversion</u>	16800.0	766.2	9137.5	6896.2
<u>Difference</u>	-0-	-7633.8	+9137.5	-1503.8

(1) Assumes conversion on January 1, 1982

(2) Assumes state share equals approximately 25% CSSA Appropriation

(3) Assumes county share at 4.56%

(4) Assumes FFP at 54.39%

TABLE II

Cost Implications of Using SILS and Rule 23 Appropriation as Match  
for Title XIX Conversion

	FY 82 (In Thousands)			
	<u>Budget</u>	<u>Cty/XX</u>	<u>XIX</u>	<u>State</u>
<u>Current Funding Mode</u>	1197.1(1)	359.1	-0-	838.0(2)
<u>Conversion</u>	1197.1	54.6	651.1	491.3
<u>Difference</u>	-0-	-304.5	+651.1	-346.7
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	FY 83			
	<u>Budget</u>	<u>Cty/XX</u>	<u>XIX</u>	<u>State</u>
<u>Current Funding Mode</u>	2137.7	641.3	-0-	1496.4
<u>Conversion</u>	2137.7	97.6	1162.7	877.4
<u>Difference</u>	-0-	-543.7	+1162.7	-619.
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Maintaining Appropriation(3)				
<u>FY 82 Conversion</u>	2041.9	93.1	1110.6	838.0
<u>FY 83 Conversion</u>	3646.2	166.3	1983.2	1496.4

(1) The total budget is computed on an estimated 70% state, 30% county match on FY 82 appropriation of \$838.0. A January 1, 1982 conversion computation would equal approximately 60% of Budget total.

(2) The conversion would save the state 346.7 of the FY 82 SILS and Rule 23 appropriation if the program were maintained at the projected level.

(3) If the total FY 82 and 83 SILS and Rule 23 appropriations were used as state match, the resultant program increase would result in an additional 940.6 for SILS in FY 82 and 1508.5 in FY 83.

Service Planning and Control

The role of the county social service agency in the planning and provision of programs and services for mentally retarded persons is established in 12 MCAR 2.185 (DPW Rule 185).

C.3.b. "Arrangements for placement in a public or private day or residential facility shall be made by the local social service agency. When in the facility the client continues to be the client of the local social service agency."

The use of the Title XIX Medicaid program to fund developmental achievement center services does not change that authority but, in fact, strengthens it. Through the process of need determination (D.4.), counties control the development of programs and services. The case management authority (A.4.a.) of the county assures that clients receive only the type and level of service they require - as determined by the county case managers.

This function of the county social service agency is critical to the issue of cost and service containment. Once local cost for residential and day programs are standardized at a fixed percentage of the non-federal share, the disincentives to placement in less expensive settings disappear and are replaced with incentives to place persons into less restrictive and less costly alternatives. In the long run, this should result in cost savings as clients moved from institutional to non-institutional settings. The programmatic and humane advantages are obvious.

#### Program Expansion

A frequently voiced concern is that the expansion of the Medical Assistance Program to include additional services will result in an uncontrollable increase of the number of persons who will demand service. In most instances, this probably occurs; however, in the case of mentally retarded persons in Minnesota, the "target" population has been identified and is currently being served for the most part in the MR service system. Only a minimal amount of "new" demand should be expected.

Additionally, given the existing control mechanisms in place under DPW Rule 185, counties can control any new demand under the need determination and case management provisions. A third level of control exists in the eligibility determination process, which is also carried out at the county level.

#### Recommendations of the Council:

1. THE DEPARTMENT OF PUBLIC WELFARE TO MOVE IMMEDIATELY TO USE THE TITLE XIX PROGRAM FOR FUNDING BOTH DEVELOPMENTAL ACHIEVEMENT SERVICES (DACS) AND SEMI-INDEPENDENT LIVING SERVICES (SILS).
2. THE DEPARTMENT OF PUBLIC WELFARE SHOULD IMMEDIATELY BEGIN DEVELOPING IMPLEMENTATION STRATEGIES AND PROCEDURES TO CARRY OUT THE PREVIOUS RECOMMENDATION.

LJ/fa